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Group Number: 00324707

# DAEMEN COLLEGE

## ALL ELIGIBLE EMPLOYEES

Here you'll find information about your following employee benefit(s). Be sure to review the enclosed - it provides everything you need to sign up for your Guardian benefits.

### PLAN HIGHLIGHTS

- Vision

### Questions? Concerns?

Helpline (888) 600-1600

Call weekdays, 7:00 AM to 8:30 PM, EST.

And refer to your plan number: 00324707

# Welcome

Dear DAEMEN COLLEGE Employee,

We are happy to have been chosen by DAEMEN COLLEGE to be the provider of your employee benefits this year. For over 150 years, we have helped millions of people plan, secure and look after their families. We believe that life's unexpected surprises should be met with the support, guidance and understanding of someone who truly cares. And, we understand the power of help. It's why we go above and beyond to do what's right for you.

With Guardian® coverage you get:

- Affordable group rates
- Convenient payroll deduction
- Benefits for your unique needs

Take advantage of the benefits offered to you at work. Feel secure knowing that you have the coverage you need from a trusted provider and that it's there when you need it most.

Guardian

GUARDIAN® is a registered trademark of The Guardian Life Insurance Company of America®. Insurance products are underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage.

2018-71635 (12/20)

## Vision Benefit Summary

**Group Number: 00324707**

**Why choose Guardian for your Vision insurance:**

- For just a few dollars a month, this coverage saves you money on optical wellness, as well as providing discounts on eyewear, contacts, and corrective vision services
- Extensive network of vision specialists and medical professionals
  - Affordable coverage
  - Quick and easy claim payments

**About Your Benefits:**

**Option 1:** Visit any doctor with your **Full Feature** plan, but save by visiting any of the 50,000+ locations in the nation's largest vision network.

**Option 2:** Significant out-of-pocket savings available with your **Full Feature** plan by visiting one of Davis Vision's network locations including retail centers such as Wal-Mart®, JCPenney®, Sears®, Target®, Sam's Club®, Pearle®, and Visionworks®.

<b>Your Vision Plan</b>	<b>Option 1: Full Feature</b>		<b>Option 2: Full Feature - Designer</b>	
<b>Your Network is</b>	VSP Network Signature Plan		Davis Vision	
<b>Copay</b>				
Exams Copay	\$ 10		\$ 10	
Materials Copay (waived for elective contact lenses)	\$ 25		\$ 25	
<b>Sample of Covered Services</b>	<i>You pay (after copay if applicable):</i>		<i>You pay (after copay if applicable):</i>	
Eye Exams	In-network \$0	Out-of-network Amount over \$50	In-network \$0	Out-of-network Amount over \$50
Single Vision Lenses	\$0	Amount over \$48	\$0	Amount over \$48
Lined Bifocal Lenses	\$0	Amount over \$67	\$0	Amount over \$67
Lined Trifocal Lenses	\$0	Amount over \$86	\$0	Amount over \$86
Lenticular Lenses	\$0	Amount over \$126	\$0	Amount over \$126
Frames	80% of amount over \$130 <sup>1</sup>	Amount over \$48	80% of amount over \$135 <sup>2</sup>	Amount over \$48
Contact Lenses (Elective)	Amount over \$130	Amount over \$120	N/A	N/A
Contact Lenses (Elective and conventional)	N/A	N/A	85% of amount over \$135*	Amount over \$105
Contact Lenses (Planned replacement and disposable)	N/A	N/A	85% of amount over \$135*	Amount over \$105
Contact Lenses (Medically Necessary)	\$0	Amount over \$210	\$0	Amount over \$210
Contact Lenses (Evaluation and fitting)	15% off UCR	No discounts	No discounts	No discounts
Cosmetic Extras	Avg. 30% off retail price	No discounts	Avg. 40-60% off retail price	No discounts
Glasses (Additional pair of frames and lenses)	20% off retail price <sup>^</sup>	No discounts	Courtesy discount from most providers	No discounts
Laser Correction Surgery Discount	Up to 15% off the usual charge or 5% off promotional price	No discounts	Up to 25% off the usual charge or 5% off promotional price	No discounts
<b>Service Frequencies</b>				
Exams	Every calendar year		Every calendar year	
Lenses (for glasses or contact lenses) <sup>†‡</sup>	Every calendar year		Every calendar year	
Frames	Every two calendar years		Every two calendar years	

Benefit information illustrated within this material reflects the plan covered by Guardian as of 05/02/2019

DAEMEN COLLEGE ALL ELIGIBLE EMPLOYEES Benefit Summary

The Guardian Life Insurance Company of America, New York, NY

Your Vision Plan	Option 1: Full Feature	Option 2: Full Feature - Designer
Network discounts (glasses and contact lens professional service)	Limitless within 12 months of exam.	Applies to first purchase & courtesy discount from most providers on subsequent purchases.
<b>Dependent Age Limits</b>	26	26

Visit [www.GuardianAnytime.com](http://www.GuardianAnytime.com) and click on "Find a Provider"

## VSP

- **VSP** Benefit includes coverage for glasses or contact lenses, not both.
- <sup>v</sup> For the discount to apply your purchase must be made within 12 months of the eye exam. In addition Full-Feature plans offer 30% off additional prescription glasses and nonprescription sunglasses, including lens options, if purchased on the same day as the eye exam from the same VSP doctor who provided the exam.
- Charges for an initial purchase can be used toward the material allowance. Any unused balance remaining after the initial purchase cannot be banked for future use. The only exception would be if a member purchases contact lenses from an out of network provider, members can use the balance towards additional contact lenses within the same benefit period.
- <sup>1</sup>Extra \$20 on select brands

## Davis

- **Davis** Benefit includes coverage for glasses or contact lenses, not both.
- Contact lenses from Davis Vision's Collection are available at most private practice locations with Full Feature and Materials Only plans. Contacts from the collection are covered in full including fitting and evaluation, in excess of the plan's materials copay. Elective contacts that are not part of the Collection are covered up to the plan's elective contact lens allowance and the materials copay is waived.
- <sup>\*</sup>Due to lower prices available at Wal-mart and Sam's Club locations, discounts do not apply. Members will pay 100% of the amount over their allowance.
- For Davis Vision, complete eyeglasses must be purchased at one time from one provider. For example, if a member purchases only lenses, he or she cannot purchase frames later in the same benefit period. The member is not eligible for new vision materials until the next benefit period. Only charges for an initial purchase can be used toward the material allowance. Any unused balance remaining after the initial purchase cannot be banked for future use.
- <sup>2</sup>Extra \$50 at Visionworks stores

*This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and actual sold plan. The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium actually billed, the latter prevails.*

## Manage Your Benefits:

Go to [www.GuardianAnytime.com](http://www.GuardianAnytime.com) to access secure information about your Guardian benefits including access to an image of your ID Card. Your on-line account will be set up within 30 days after your plan effective date.

## Need Assistance?

Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your member ID (social security number) and your plan number: 00324707.

**Please call the Guardian Helpline if you need to use your benefits within 30 days of plan effective date.**

**Please note, self-serve options over the phone or online at Guardian Anytime are not available until the case is fully implemented, please wait to speak to a live agent when calling the Guardian Helpline.**

## EXCLUSIONS AND LIMITATIONS

*Important Information:* This policy provides vision care limited benefits health insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department. Coverage is limited to those charges that are necessary for a routine vision examination. Co-pays apply. The plan does not pay for: orthoptics or vision training and any associated supplemental testing; medical or surgical treatment of the eye; and eye examination or corrective eyewear required by an employer as a condition of employment; replacement of lenses and frames that are furnished under this plan, which are lost or broken (except at normal intervals when services are otherwise available or a warranty exists). The plan limits benefits for blended lenses, oversized lenses, photochromic lenses, tinted lenses, progressive multifocal lenses, coated or laminated lenses, a frame that exceeds plan allowance, cosmetic lenses; U-V protected lenses and optional cosmetic processes.

The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract #GP-1-DAVIS-05-VIS et al, Contract #GP-1-VSN-96-VIS et al.

### **Laser Correction Surgery:**

Laser surgery is not an insured benefit. The surgery is available at a discounted fee. The covered person must pay the entire discounted fee. In addition, the laser surgery discount may not be available in all states.



## **NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

### **PLEASE REVIEW IT CAREFULLY.**

**Effective: 05/01/2016**

This Notice of Privacy Practices describes how Guardian and its subsidiaries may use and disclose your Protected Health Information (PHI) in order to carry out treatment, payment and health care operations and for other purposes permitted or required by law.

Guardian is required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices concerning PHI. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all PHI maintained by us. If we make material changes to our privacy practices, copies of revised notices will be made available on request and circulated as required by law. Copies of our current Notice may be obtained by contacting Guardian (using the information supplied below), or on our Web site at [www.guardianlife.com/privacy-policy](http://www.guardianlife.com/privacy-policy).

#### **What is Protected Health Information (PHI):**

PHI is individually identifiable information (including demographic information) relating to your health, to the health care provided to you or to payment for health care. PHI refers particularly to information acquired or maintained by us as a result of your having health coverage (including medical, dental, vision and long term care coverage).

#### **In What Ways may Guardian Use and Disclose your Protected Health Information (PHI):**

Guardian has the right to use or disclose your PHI without your written authorization to assist in your treatment, to facilitate payment and for health care operations purposes. There are certain circumstances where we are required by law to use or disclose your PHI. And there are other purposes, listed below, where we are permitted to use or disclose your PHI without further authorization from you. Please note that examples are provided for illustrative purposes only and are not intended to indicate every use or disclosure that may be made for a particular purpose.

Guardian has the right to use or disclose your PHI for the following purposes:

Treatment. Guardian may use and disclose your PHI to assist your health care providers in your diagnosis and treatment. For example, we may disclose your PHI to providers to supply information about alternative treatments.

Payment. Guardian may use and disclose your PHI in order to pay for the services and resources you may receive. For example, we may disclose your PHI for payment purposes to a health care provider or a health plan. Such purposes may include: ascertaining your range of benefits; certifying that you received treatment; requesting details regarding your treatment to determine if your benefits will cover, or pay for, your treatment.

Health Care Operations. Guardian may use and disclose your PHI to perform health care operations, such as administrative or business functions. For example, we may use your PHI for underwriting and premium rating purposes. However, we will not use or disclose your genetic information for underwriting purposes and are prohibited by law from doing so.

Appointment Reminders. Guardian may use and disclose your PHI to contact you and remind you of appointments.

Health Related Benefits and Services. Guardian may use and disclose PHI to inform you of health related benefits or services that may be of interest to you.

Plan Sponsors. Guardian may use or disclose PHI to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan may contact us regarding benefits, service or coverage issues. We may also disclose summary health information about the enrollees in your group health plan to the plan sponsor so that the sponsor can obtain premium bids for health insurance coverage, or to decide whether to modify, amend or terminate your group health plan.

Guardian is required to use or disclose your PHI:

- To you or your personal representative (someone with the legal right to make health care decisions for you);
- To the Secretary of the Department of Health and Human Services, when conducting a compliance investigation, review or enforcement action related to health information privacy or security; and
- Where otherwise required by law.

Guardian is Required to Notify You of any Breaches of Your Unsecured PHI.

Although Guardian takes reasonable, industry-standard measures to protect your PHI, should a breach occur, Guardian is required by law to notify affected individuals. Under federal medical privacy law, a breach means the acquisition, access, use, or disclosure of unsecured PHI in a manner not permitted by law that compromises the security or privacy of the PHI.

Other Uses and Disclosures.

Guardian may also use and disclose your PHI for the following purposes without your authorization:

- We may disclose your PHI to persons involved in your care or payment for care, such as a family member or close personal friend, when you are present and do not object, when you are incapacitated, under certain circumstances during an emergency or when otherwise permitted by law.
- We may use or disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- We may use or disclose your PHI in an emergency, directly to or through a disaster relief entity, to find and tell those close to you of your location or condition
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI to a government oversight agency authorized by law to conducting audits, investigations, or civil or criminal proceedings.
- We may use or disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for organ or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services.
- We may use or disclose your PHI to comply with workers' compensation and other similar programs.
- We may disclose your PHI to third party business associates that perform services for us, or on our behalf (e.g. vendors).
- We may use and disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to authorized federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations authorized by law.
- We may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official (e.g., for the institution to provide you with health care services, for the safety and security of the institution, and/or to protect your health and safety or the health and safety of other individuals).
- We may use or disclose your PHI to your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

We generally will not sell your PHI, or use or disclose PHI about you for marketing purposes without your authorization unless otherwise permitted by law.

**Your Rights with Regard to Your Protected Health Information (PHI):**

Your Authorization for Other Uses and Disclosures. Other than for the purposes described above, or as otherwise permitted by law, Guardian must obtain your written authorization to use or disclose your PHI. You have the right to revoke that authorization in writing except to the extent that: (i) we have taken action in reliance upon the authorization prior to your written revocation, or (ii) you were required to give us your authorization as a condition of obtaining coverage, and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Under federal and state law, certain kinds of PHI may require enhanced privacy protections. These forms of PHI include information pertaining to:

- HIV/AIDS testing, diagnosis or treatment
- Venereal and/or communicable Disease(s)
- Genetic Testing
- Alcohol and drug abuse prevention, treatment and referral
- Psychotherapy notes

We will only disclose these types of delineated information when permitted or required by law or upon your prior written authorization.

Your Right to an Accounting of Disclosures. An ‘accounting of disclosures’ is a list of certain disclosures we have made, if any, of your PHI. You have the right to receive an accounting of certain disclosures of your PHI that were made by us. This right applies to disclosures for purposes other than those made to carry out treatment, payment and health care operations as described in this notice. It excludes disclosures made to you, or those made for notification purposes.

We ask that you submit your request in writing by completing our form. Your request may state a requested time period not more than six years prior to the date when you make your request. Your request should indicate in what form you want the list (e.g., paper, electronically). Our form for Accounting of Disclosure requests is available at [www.guardianlife.com/privacy-policy](http://www.guardianlife.com/privacy-policy).

Your Right to Obtain a Paper Copy of This Notice. You have a right to request a paper copy of this notice even if you have previously agreed to accept this notice electronically. You may obtain a paper copy of this notice by sending a request to the contact information listed at the end of this notice.

Your Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with Guardian or the Secretary of U.S. Department of Health and Human Services. If you wish to file a complaint with Guardian, you may do so using the contact information below. You will not be penalized for filing a complaint.

Please submit any exercise of the Rights designated below to Guardian in writing using the contact information listed below. For some requests, Guardian may charge for reasonable costs associated with complying with your requests; in such a case, we will notify you of the cost involved and provide you the opportunity to modify your request before any costs are incurred.

Your Right to Request Restrictions. You have the right to request a restriction on the PHI we use or disclose about you for treatment, payment or health care operations as described in this notice. You also have the right to request a restriction on the medical information we disclose about you to someone who is involved in your care or the payment for your care.

Guardian is not required to agree to your request; however, if we do agree, we will comply with your request until we receive notice from you that you no longer want the restriction to apply (except as required by law or in emergency situations). Your request must describe in a clear and concise manner: (a) the information you wish restricted; (b) whether you are requesting to limit Guardian’s use, disclosure or both; and (c) to whom you want the limits to apply.

Your Right to Request Confidential Communications. You have the right to request that Guardian communicate with you about your PHI be in a particular manner or at a certain location. For example, you may ask that we contact you at work rather than at home. We are required to accommodate all reasonable requests made in writing, when such requests clearly state that your life could be endangered by the disclosure of all or part of your PHI.

Your Right to Amend Your PHI If you feel that any PHI about you, which is maintained by Guardian, is inaccurate or incomplete, you have the right to request that such PHI be amended or corrected. Within your written request, you must provide a reason in support of your request. Guardian reserves the right to deny your request if: (i) the PHI was not created by Guardian, unless the person or entity that created the information is no longer available to amend it (ii) if we do not maintain the PHI at issue (iii) if you would not be permitted to inspect and copy the PHI at issue or (iv) if the PHI we maintain about you is accurate and complete. If we deny your request, you may submit a written statement of your disagreement to us, and we will record it with your health information.

Your Right to Access to Your PHI. You have the right to inspect and obtain a copy of your PHI that we maintain in designated record sets. Under certain circumstances, we may deny your request to inspect and copy your PHI. In an instance where you are denied access and have a right to have that determination reviewed, a licensed health care professional chosen by Guardian will review your request and the denial. The person conducting the review will not be the person who denied your request. Guardian promises to comply with the outcome of the review.



**How to Contact Us:**

If you have any questions about this Notice or need further information about matters covered in this Notice, please call the toll-free number on the back of your Guardian ID card. If you are a broker please call 800-627-4200. All others please contact us at 800-541-7846. You can also write to us with your questions, or to exercise any of your rights, at the address below:

Attention:           Guardian Corporate Privacy Officer  
                          National Operations

Address:            The Guardian Life Insurance Company of America  
                          Group Quality Assurance - Northeast  
                          P.O. Box 2457  
                          Spokane, WA 99210-2457

# WorkLifeMatters

## Your Confidential Employee Assistance Program – Helping find balance between work and home life.

WorkLifeMatters provides guidance for personal issues that you might be facing and information about other concerns that affect your life, whether it's a life event or on a day-to-day basis.

- **Unlimited free telephonic consultation with an EAP counselor available 24/7 at 800-386-7055**
- **Referrals to local counselors — up to three sessions free of charge**
- **State-of-the-art website featuring over 3,400 helpful articles on topics like wellness, training courses, and a legal and financial center**

### WorkLifeMatters can offer help with:

<b>Education</b> <ul style="list-style-type: none"><li>▪ Admissions testing &amp; procedures</li><li>▪ Adult re-entry programs</li><li>▪ College Planning</li><li>▪ Financial aid resources</li><li>▪ Finding a pre-school</li></ul>	<b>Dependent Care &amp; Care Giving</b> <ul style="list-style-type: none"><li>▪ Adoption Assistance</li><li>▪ Before/after school programs</li><li>▪ Day Care/Elder Care</li><li>▪ Elder care</li><li>▪ In-home services</li></ul>	<b>Legal and financial</b> <ul style="list-style-type: none"><li>▪ Basic tax planning</li><li>▪ Credit &amp; collections</li><li>▪ Debt Counseling</li><li>▪ Home buying</li><li>▪ Immigration</li></ul>
<b>Lifestyle &amp; Fitness Management</b> <ul style="list-style-type: none"><li>▪ Anxiety &amp; depression</li><li>▪ Divorce &amp; separation</li><li>▪ Drugs &amp; alcohol</li></ul>	<b>Working Smarter</b> <ul style="list-style-type: none"><li>▪ Career development</li><li>▪ Effective managing</li><li>▪ Relocation</li></ul>	

For more information about WorkLifeMatters, go to [www.ihworklife.com](http://www.ihworklife.com); User Name: Matters; Password: wlm70101

WorkLifeMatters Program services are provided by Integrated Behavioral Health, Inc., and its contractors. Guardian does not provide any part of WorkLifeMatters Program services. Guardian is not responsible or liable for care or advice given by any provider or resource under the program. This information is for illustrative purposes only. It is not a contract. Only the Administration Agreement can provide the actual terms, services, limitations and exclusions. Guardian and IH reserve the right to discontinue the WorkLifeMatters Program at any time without notice. Legal services provided through WorkLifeMatters will not be provided in connection with or preparation for any action against Guardian, IH, or your employer.



# THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

Group Insurance Enrollment Form

Page 1 of 4

Guardian Life, P.O. Box 14319,  
Lexington, KY 40512

Please print clearly and mark carefully.

Employer Name: <b>DAEMEN COLLEGE</b>	Group Plan Number: <b>00324707</b>	Benefits Effective: _____
PLEASE CHECK APPROPRIATE BOX	Initial Enrollment	Re-Enrollment
Increase Amount	Family Status Change	Add Employee/Dependents
		Drop/Refuse Coverage
		Information Change

Class: \_\_\_\_\_ Division: \_\_\_\_\_ Subtotal Code: \_\_\_\_\_ (Please obtain this from your Employer)

**About You:**  
 First, MI, Last Name: \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Gender: M F Date of Birth (mm-dd-yy): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Are you married or do you have a spouse? Yes No Date of marriage/union: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Do you have children or other dependents? Yes No Placement date of adopted child: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**About Your Job:** Hours worked per week: \_\_\_\_\_ Job Title: \_\_\_\_\_  
 Work Status: Active Retired Cobra/State Continuation Date of full time hire: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**About Your Family:** Please include the names of the dependents you wish to enroll for coverage. A dependent is a person who relies on you for financial support; and for whom you qualify for a dependent tax exemption. Dependent tax exemptions are subject to IRS rules and regulations. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.

Spouse (First, MI, Last Name)	Gender	Social Security Number	
Address/City/State/Zip:	M F	Date of Birth (mm-dd-yyyy)	
Phone: ( ) -			
Child/Dependent 1:	Add Drop Gender	Social Security Number	Status (check all that apply)
Address/City/State/Zip:	M F	Date of Birth (mm-dd-yyyy)	Student (post high school) Non standard dependent Disabled
Phone: ( ) -			
Child/Dependent 2:	Add Drop Gender	Social Security Number	Status (check all that apply)
Address/City/State/Zip:	M F	Date of Birth (mm-dd-yyyy)	Student (post high school) Non standard dependent Disabled
Phone: ( ) -			

Child/Dependent 3: Address/City/State/Zip: Phone: (    ) -    -	Add	Drop	Gender M    F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Student (post high school) Non standard dependent	Disabled
Child/Dependent 4: Address/City/State/Zip: Phone: (    ) -    -	Add	Drop	Gender M    F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Student (post high school) Non standard dependent	Disabled

<b>Drop Coverage:</b> Drop Employee      Drop Dependents The date of withdrawal cannot be prior to the date this form is completed and signed. Last Day of Coverage:      -    - Termination of Employment      Retirement Last Day Worked:      -    - Other Event: _____ Date of Event:      -    -	<b>Coverage Being Dropped:</b> Vision      Employee      Spouse      Child(ren)
<b>Loss Of Other Coverage:</b> I and/or my dependents were previously covered under another insurance plan. Loss of coverage was due to: Termination of Employment:      -    - Divorce      -    - Death of Spouse      -    - Termination/Expiration of Coverage      -    - Coverage Lost      Vision	I have been offered the above coverage(s) and wish to drop enrollment for the following reasons: Covered under another insurance plan Other _____ (additional information may be required)

**Vision Coverage: You must be enrolled to cover your dependents. Check only one box.**

Option 1: Full Feature      Employee Only      EE, Spouse & Dependent/Child(ren)  
 Option 2: Full Feature - Designer

I do not want this coverage. If you do not want this Vision Coverage, please mark all that apply:

    I am covered under another Vision plan  
     My spouse is covered under another Vision plan  
     My dependents are covered under another Vision plan

**Signature**

An employee's decision to elect Vision or not elect Vision must be retained until the next plan's Open Enrollment period. If the employee elects not to enroll in vision coverage, they are not eligible to enroll until the plan's next Open Enrollment period.

I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.

Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.

If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.

Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.

I hereby apply for the group benefit(s) that I have chosen above.

I understand that I must meet eligibility requirements for all coverages that I have chosen above.

I agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above.

I agree that my [employee] or my employer's designated administrator may deduct premiums from my pay apply premiums to my credit card or debit card add premiums to my dues withdraw premiums from my designated bank account, apply premiums to my credit or debit card if they are required for the coverage I have chosen.

I acknowledge and consent to receiving electronic copies of insurance related documents, in lieu of paper copies, to the extent permitted by applicable law  
I voluntarily agree to that arrangement. I do not agree to that arrangement. I understand that I may change my election by providing Guardian 30 day prior written notice.

**I state that the information provided above is true and correct to the best of my knowledge.**

**Any person who with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially, false information, or conceals for purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil Penalties, or denial of insurance benefits (Does not apply to Life Insurance).**

**The laws of New York require the following statement appear: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)**

**READ YOUR CERTIFICATE CAREFULLY. CERTAIN WAR RISKS ARE NOT ASSUMED. IN CASE OF ANY DOUBT, CONTACT YOUR COMPANY FOR FURTHER EXPLANATION.**

**The following section applies to these coverage(s): Accident Coverage, Specified Disease Coverage, Hospital Indemnity Coverage:**

**NOTICE TO CONSUMER:** THIS COVERAGE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

**SIGNATURE OF EMPLOYEE X** \_\_\_\_\_

**DATE** \_\_\_\_\_

Enrollment Kit 00324707, 0001, EN

### Fraud Warning Statements

**The laws of several states require the following statements to appear on the enrollment form:**

**Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

**Arizona:** For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**California:** For your protection California law requires the following to appear on this form: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

**Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Connecticut, Iowa, Nebraska, and Oregon:** Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

**Delaware, Indiana and Oklahoma:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

**Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Kansas:** Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud as determined by a court of law.

**Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Louisiana and Texas:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

**Maine, Tennessee and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Maryland :** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Rhode Island:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20

**New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New Mexico:** Any person who knowingly presents a false or fraudulent claim for payment or a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties or denial of insurance benefits.

**Ohio:** Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Vermont:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

**Virginia:** Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.